ALPHA OMEGA

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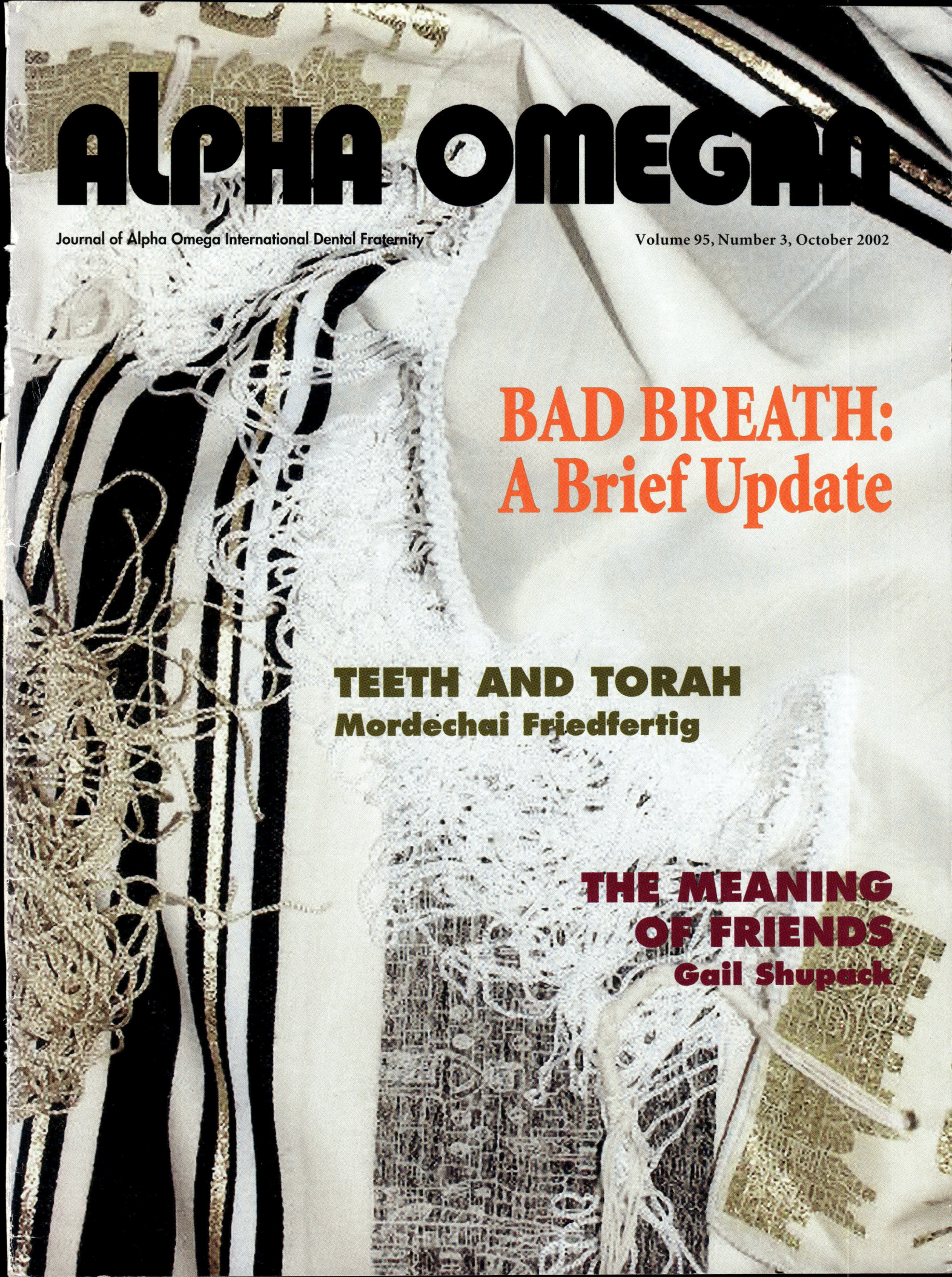
Volume 95, Number 3, October 2002



BAD BREATH: A Brief Update

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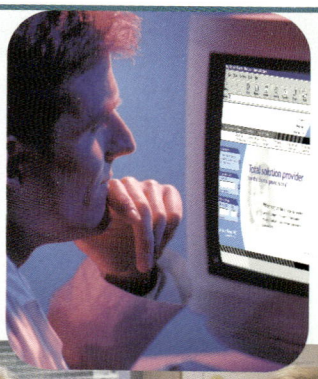

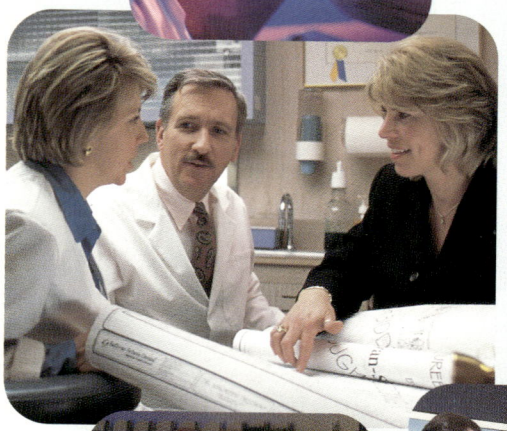

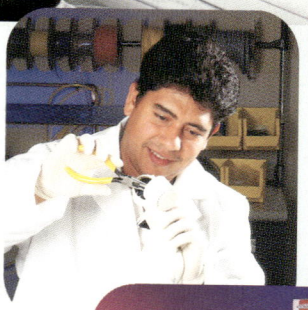

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increase only when that goal is reached. We know that the greatest value that we gain from our membership is in the sharing of ideas among friends who possess a similar basis for their success in life. Our work ethic and that entrepreneurial spirit drive us to be successful in our personal lives as well as being the driving force behind this fraternity. For me, Alpha Omega has added greatly to my success in life, and for that my family and I are thankful.

Fraternally,
Richard S. Shapiro
International President

ALPHA OMEGA

concerné de la fraternité. Mais si mes réflexions s'arrêtent ici et que vous n' allez pas de l'avant dans vos communautés pour recruter davantage de membres, nous ne pouvons pas réussir. Regroupons donc nos efforts pour ces dernières années du centenaire d'Alpha Omega pour augmenter de manière conséquente le nombre de nos membres à la base. Les services que nous recevront ne pourront s'améliorer que quand ce but aura été atteint. Nous savons que notre plus grand atout en tant que membre réside dans le fait d' échanger nos idées avec des amis qui ont les mêmes bases pour leur succès dans la vie. Notre éthique professionnelle et notre esprit d'entreprise nous permettent de réussir dans nos vies personnelles et d'être aussi les forces actives derrière notre fraternité. Pour moi Alpha Omega a largement contribuer à mon succès dans la vie et de cela ma famille est reconnaissante.

Fraternellement,
Richard S. Shapiro
Président International

Traduction Roselyne Elbaum Freeman

Israeli-American Biotech Conference To Be Held November 8–10, 2002, in New York City

Regimedia, USA has organized a biotech conference to be held in New York City this November. Regimedia is the company that publishes the French *AO News* for Alpha Omega in France. For information on this conference, contact Esther Buck or Julia Douthart, 200 East 64th Street, Suite 10C, New York, NY 10021, 212-750-7257.

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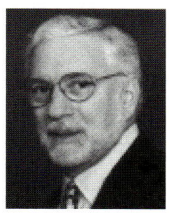

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SCIENTIFIC ARTICLE

Bad Breath: A Brief Update

Mel Rosenberg, Ph.D.

Oral malodor is becoming a subject of growing interest on the part of dental professionals. It is one of the main reasons that people worldwide seek dental advice. Unfortunately, the subject is barely taught in most dental faculties. That is changing, and it is hoped that within the next decade, courses on oral malodor will be offered at both the undergraduate and graduate levels. In the meantime, there is an ongoing need to keep practicing dentists abreast of research developments in this area. This challenge is complicated by the multitude of hype promoting specific clinics and treatments that abound on the Internet and elsewhere. The purpose of the present article is to answer several questions frequently asked by both dental professionals and patients concerning bad breath and to suggest additional avenues for obtaining further information.

Should dental professionals be interested in bad breath?

Absolutely. According to research done in Israel, North America, Belgium and the United Kingdom, in most cases (about 85 to 90%), bad breath comes from the mouth itself.[1–5] Concern about bad breath is one of the main reasons that patients seek dental counsel. Proper diagnosis and treatment of bad breath are important for the care of current patients and can help bring in new patients who have been previously unaware that dentists are the professionals who should be consulted first in this regard. Making patients aware of the link among oral hygiene, dental care and bad breath can lead to significant improvements in compliance, especially with respect to dental flossing.[6]

Mel Rosenberg, Ph.D.
Dr. Mel Rosenberg is professor of microbiology at the Maurice and Gabriela Goldschleger School of Dental Medicine at Tel Aviv University. For the past 15 years, his research has focused on finding new ways to diagnose and treat oral malodor.

In the mouth, where does the odor come from?

As with many other foul odors (foot and shoe odor, underarm odor, garbage odor, wet towel odor), microorganisms are responsible (Fig. 1). Previously, bad breath was considered to be solely attributable to gram-negative microorganisms, including many that have been implicated in periodontal disease, such as *Porphyromonas gingivalis*. These bacteria break proteins down into their component amino acids and then metabolize the amino acids further, yielding breakdown products, some of which are volatile. Recent research by Dr. Nir Sterer in our laboratory suggests that gram-positive microorganisms, such as the relatively innocuous *Streptococcus salivarius*, may also play a role in bad breath by breaking the sugar residues off oral glycoproteins, enabling the gram-negative proteases to continue to break down the denuded polypeptides. Indeed, when sterilized saliva was allowed to incubate first in the presence of *S. salivarius*, and only then in the presence of *P. gingivalis*, was more odor produced.[7]

In the 1960s and 1970s, Dr. Joseph Tonzetich (University of British Columbia) and his students were responsible for showing that bad breath is related to sulfur-containing breakdown products, primarily hydrogen sulfide and methylmercaptan.[2] Other researchers think that additional breakdown products (i.e., indole, skatole and cadaverine) are also involved. In addition to their putrid smell, these odorous molecules are toxic and may contribute to periodontal disease.[3,4]

The bacteria that produce these odors thrive in sequestered areas that protect the bacteria from being washed away by mechanical actions and enables the development of anaerobic conditions. These areas include interdental and subgingival plaque, underneath and around the margins of leaking crowns and

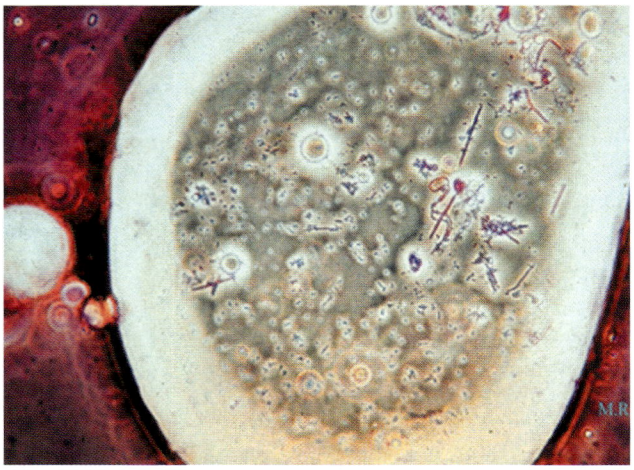

Figure 1. Oral bacteria removed from the mouth on the surface of an oil droplet.

Figure 2. Yellow discharge, suggestive of postnasal drip, removed from the posterior part of the tongue dorsum.

failed bridgework, uneven margins, partially impacted molars, areas of food impaction, unclean dentures, etc.[4]

Surprisingly, many patients with excellent dentition, gingiva and oral hygiene practices still suffer from bad breath.[5] This is because the tongue dorsum is one of the major sites for odor production. Just by licking one's wrist and then smelling it, one can readily attest to the prevailing odor. However, even more odor lurks far back on the tongue dorsum, toward the throat. The odor at the very far back of the tongue can be gently sampled with a plastic spoon.[4] The material scooped up onto the spoon (Fig. 2) often smells very similar to the odor coming from the patient's mouth. This may be linked to postnasal drip, which can allow mucus to accumulate at the very back of the tongue. Although it may not smell bad when it initially reaches that location, the mucus quickly becomes putrefied by the billions of bacteria that routinely inhabit the tongue. This area of the tongue is not properly cleansed by routine oral activity (i.e., swallowing) but can be cleaned by gentle sweeping using tongue cleaners, which are becoming widely available (Fig. 3).

How can one determine if the odor has an oral origin?

There is a simple century-old test. The dental professional asks the patient to first breathe out from the mouth. The patient is then asked to breathe out from the nose. The odors are then compared. If the smell is coming primarily from the mouth, then an oropharyngeal source can be inferred. If the odor is coming primarily from the nose, then the lungs, bronchi and/or nasal passages may be the source. In the unlikely event that the odor is owing to a systemic problem, it will be encountered both in the breath coming from the mouth and the nose.

Another simple way to help the clinician to determine the involvement of the oral cavity is to have the patient rinse and gargle for a week with an effective mouthwash to see whether or not the odor abates.

Quantitative instruments and biochemical tests are available that provide rapid measurements of the volatile sulfides and enzymes that are associated with bad breath (Fig. 4). These measurements provide a back-up for the "sniff" assessments and are very helpful in monitoring improvements, but they still do not take the place of the human nose. More

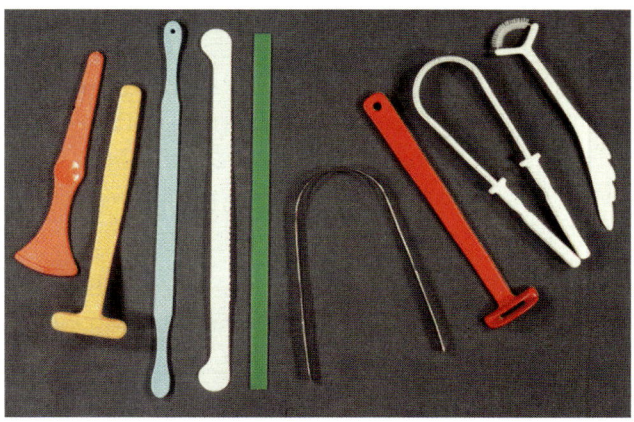

Figure 3. Many kinds of tongue cleaners are currently available.

Figure 4. The volatile sulfide component of oral malodor can be measured using a sulfide monitor (Interscan Corp.).

sophisticated "electronic noses" are currently under development.

What are other reasons for having bad breath?

Aside from the mouth, bad breath can come from the nasal passages (in about 5 to 10% of cases), for example, because of sinusitis or foreign bodies. There is some controversy regarding the role of the tonsils, but they are generally considered to be responsible in a small proportion (perhaps 1 to 3%) of cases.[1] Bad breath can come from various diseases and metabolic problems, but these are relatively rare. Bad breath from the stomach is, contrary to public opinion, extremely rare.[4]

Sometimes I cough up little whitish stones. When I rub them between my fingers, they have a terrible odor. What are they? Does this mean I have terribly bad breath as well?

I am frequently asked these questions. The little whitish stones are called "tonsilloliths" (Fig. 5). They are calcified deposits of bacteria and debris that develop in crypts in the tonsils. Although these stones smell awful, particularly when crushed, their presence is not necessarily an indication of bad breath. However, people who suffer from them often think that their breath must be as bad as the stones.[4] In my estimation, about 2 to 3% of the population have experienced this phenomenon.

I have a patient who is convinced he/she has bad breath, although I cannot detect it. What should I do?

Bad breath usually defies self-assessment. As a result, millions of people have bad breath but are unaware of it. At the same time, millions of others worry excessively that they have it, although they do not. This latter group of individuals has been called "halitophobics."[5] Frequently, halitophobics are so sure that they have bad breath that they refuse to seek psychological or psychiatric counsel. To help qualify a clinical assessment, we are currently developing a color test (Fig. 6) that indicates whether there are high levels of associated bacteria in the patient's saliva.

Many mouthwashes are available. Which should I recommend?

This is a commonly asked question, especially because the public relies heavily on professional opinions. Dentists and hygienists are not necessarily trained to evaluate chemical products, but they are trained to evaluate scientific papers. The answer, then, is that to make a decision about the pros and cons of a given mouthwash (or, for that matter, any commercially offered treatment), the dental professional should ask to see the original peer-reviewed scientific evidence supporting the claims (in this case, oral malodor reduction). Regardless of which mouthwash the dentist decides to recommend, there are several tips that will enhance the activity of any commercial mouthwash:

- Rinse and gargle with your tongue extended. Gargling is important as it allows the mouthwash to come into contact with microorganisms at the posterior of the tongue dorsum.
- Don't eat or drink for at least 30 minutes after rinsing to allow the mouthwash residue to linger and act.
- The best time to use a mouthwash is just before

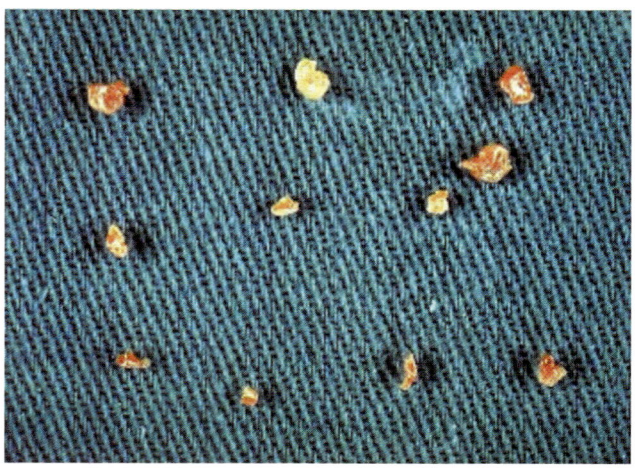

Figure 5. Tonsilloliths collected by an individual patient.

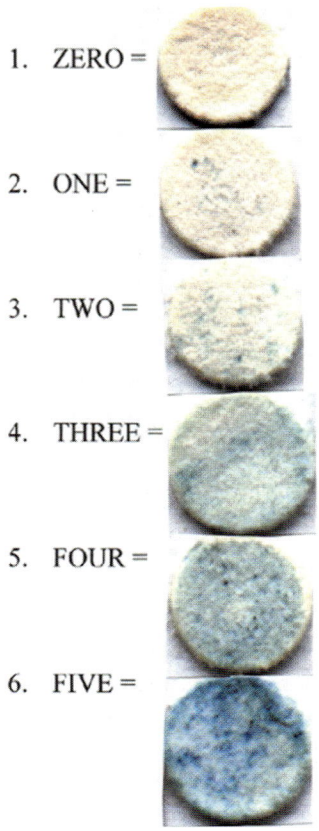

Figure 6. The "OK-To-Kiss" gives a rapid color indication of the level of an enzyme related to malodor production.

bed, when the saliva flow is lowest and bacterial odor production is highest.

- Most mouthwashes have cationic antibacterial agents (e.g., cetylpyridinium chloride) as active agents. These compounds are rendered inactive by the anionic detergent in toothpastes, so it is not advisable to use toothpaste and mouthwash at the same time. We sometimes advise patients to pour out a little mouthwash, dip their toothbrush into it, brush their teeth and then rinse and gargle with the remainder.

How effective are tongue cleaning and flossing?

Tongue Cleaning

Although toothbrushing is very important in the long term, tongue cleaning is more effective for short-term reduction of bad breath. Currently, many different kinds of plastic tongue cleaners are available (see Fig. 3). Several words of advice:

- Since the posterior of the tongue (near the throat) is the area where the odor builds up, effective tongue cleaning often involves gagging sensations. These usually abate over time. Gaggers should use flat tongue cleaners to avoid touching the soft palate.
- Some patients clean their tongues overaggressively, resulting in trauma to the tongue, which can sometimes be quite severe and perhaps dangerous. In such instances, avoid sharp metal tongue scrapers. Stress the need to clean the posterior of the tongue very gently, with a sweeping, rather than scraping, motion.
- Check to make sure that the tongue cleaners you recommend are not brittle and cannot break in the mouth.
- Since the tongue dorsum can harbor periodontal pathogens, and tongue coatings may be thicker in subjects with periodontal disease, the possibility exists that tongue cleaning may, over time, improve gingival health as well.

Flossing

In a clinical study we did a few years ago, subjects who flossed their teeth had significantly less bad breath and significantly better gingival health than patients who did not.[5] Flossing is a chore, and few patients practice it religiously. However, once the dentist emphasizes that patients who floss have less malodor than those who do not, compliance improves tremendously. If the patient is unconvinced, just ask him/her to smell the floss after passing it between his/her molars.

How can I tell someone that he/she has bad breath?

I am often asked this question and I do not have any simple solutions. Certainly, we should tell loved ones if they have this problem since no one else is likely to. Kind yet frank words are best. Brave people can consider telling close friends, hoping that the initial humiliation will give way to eventual gratitude (as often, but not always, happens). In any case, it is best to be suggestive (rather than direct) when telling your patients that they might have a problem. For example, you might try "Did you know that people who don't brush their teeth, floss and use tongue cleaners stand the risk of having bad breath?"

If you wish to inform someone discreetly and anonymously that they have bad breath, you are wel-

come to e-mail me (<melros@post.tau.ac.il>) their e-mail address and I will be happy to send a kind note.

How did you get involved in such a peculiar area of research?

I am often asked this question also. I do not think that any starry-eyed child dreams of someday growing up and making a living smelling other people's mouths. The truth is that 20 years ago, I was a graduate student in microbiology looking at how oil-eating bacteria stick to oil droplets, with the general purpose of using microorganisms to treat oil spills. After joining the dental school at Tel Aviv University in 1982, Ervin Weiss and I found that dental plaque bacteria also tend to stick avidly to oil droplets (see Fig. 1). My colleagues and I spent the next decade developing an oil/water mouthrinse with long-lasting antimalodor properties[7] and dreamed of the day when it would become an over-the-counter product. This dream came true in 1992, when the first two-phase mouthwash was launched in Israel. The British version (Dentyl pH™) is now sold throughout the United Kingdom and it is hoped that a North American version will be available in 2003.

Breath Odor Research
Vol. 1, No. 2 May 1997
Breath Odor Research
Official Newsletter of the International Society for Breath Odor Research (ISBOR)
Vol. 1, No. 3 September
Breath Odor Res
Official Newsletter of the International Society for Breath Odor
The Third International
on Breath Odour – a Gre

Figure 7. *Breath Odor News*, published by the International Society for Breath Odor Research (ISBOR).

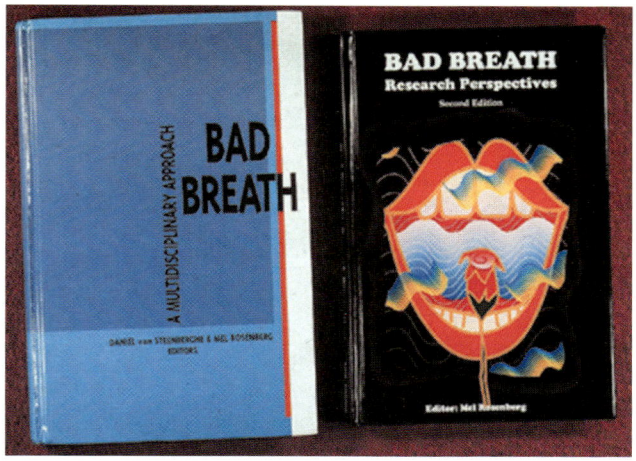

Figure 8. Two scientific textbooks on bad breath.

Further Information

International Society for Breath Odor Research

Six years ago, we launched an international organization, the International Society for Breath Odor Research (ISBOR). The aim of this society is to promote research on bad breath and the dissemination of information on this subject worldwide. The society publishes a newsletter and promotes international meetings on breath odor research (Fig. 7). The 5th international ISBOR meeting, held last summer in Tokyo, included over 50 scientific presentations and drew an audience of over 300 researchers and clinicians. The next meeting will be held September 16 to 18 in London, UK.

Tel Aviv University Website

We maintain an extensive website on the subject that is freely accessible and has been visited some 300,000 times (<http://www.tau.ac.il/~melros/>). The Website also carries information on ISBOR.

Factfile on Bad Breath/British Dental Association

A factfile on bad breath is available free of charge from the British Dental Association and can be viewed on the website above as well.

Acknowledgments

Alpha Omega has supported our research on oral malodor since I joined the dental school in 1982, and we owe a great debt to the support of fraters worldwide. Many thanks to Rellu Samuel for providing the figures (Fig. 8).

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BOOK REVIEW

Oral and Maxillofacial Infections, Fourth Edition

Author:	Richard Topazian, Morton H. Goldberg, James R. Hupp
Publisher:	Elsevier Science Canada W.B. Saunders 800-387-7278
ISBN:	72692710
Pages:	544
Price:	CAN $259.00

This new edition has contributions from more than 20 leading authorities from several medical and dental faculties. Topics new to this edition include anatomic considerations, antimicrobial pharmacology, pulpal infections, infection related to reconstruction and infections in pediatric patients. Several chapters have been revised to address early and late complications, bacterial and protozoal infections and hepatitis and acquired immune deficiency syndrome (AIDS). This text serves as the leading authority on the contemporary aspects of infections and will aid clinicians and students in dealing more effectively with infections of the oral and maxillofacial regions.

The constantly evolving flora of human infection, the advent of the opportunistic and nosocomial infections, the plethora of currently available antibiotics and newer surgical techniques demand that the student, clinician and academician keep abreast of contemporary advances in this field. This book fulfills this need.

Paul Chapnick, D.D.S., F.R.C.D.(C), F.A.D.S.A.

FEATURE ARTICLE

The Nightmare of the Estate Sale

Richard Williams, D.D.S.*

Selling a professional practice is complicated under the best of circumstances; selling the practice of a deceased doctor is many, many times more difficult. Ideally, the practice should be sold immediately, or certainly within 30 days because the value plummets rapidly.

Doctors Advisors often receives requests from other doctors to contact the spouse or family of a recently deceased doctor. They contact us because they are aware of the unique ability and services that we have to offer in a time of crisis such as this. However, as the family is going through an emotionally traumatic experience, well-meaning friends and advisors will try to offer their limited views on what the family should do with the practice. Unfortunately, none of them will typically have the experience to provide the necessary guidance and family members may be forced to make decisions that they are ill-equipped to handle.

Doctors Advisors does not actively pursue estate sale business because these very trying circumstances make it difficult to complete a transaction in a timely manner. However, we would like to provide some suggestions for consideration by the family of a deceased doctor. Please accept these suggestions in the spirit in which they are offered. This is not an effort to solicit your business; it is an effort to help you during a difficult time.

Please consider the following suggestions:

- DO get the practice evaluated immediately.
- DON'T get the tangible office assets inventoried. It takes too much time. The value of a practice is based more on its business, not the equipment and supplies. An office has a usual and customary amount of supplies that can be estimated. Equipment and supplies usually only account for a small percentage of the value of the practice, so it will not affect the actual selling price. If you wait for the specific value of these items, you could possibly lose tens of thousands of dollars in overall value. Get the practice sold; the value of a practice will decline by about 10% per week for the first 6 weeks (this is considering an already depreciated value because of the death of the owner). After that, you will have little left but scrap value.
- DO get copies of the last 3 years of tax returns, the office lease and employment contracts with associates (if any) and have them ready to be reviewed by a potential purchaser. Talk to the landlord to determine if the lease can be assigned. If you own the building, have a 5-year lease prepared by your attorney (leave the name blank until you have a purchaser) and have a copy ready to give to a potential purchaser.
- DON'T allow a potential purchaser to work in the practice until the contracts have been signed and the transaction has been completed.
- DON'T allow another doctor to "keep the practice running" unless that doctor is no potential threat to the practice value. A purchaser is not going to want to buy a practice where the owner has died and the patients have been introduced to another doctor. They will be afraid that the patients will stay with the "temporary" doctor (and many of them will).
- DON'T have a group of colleagues cover the practice until a buyer is located. Potential buyers are scared off by the presence of other competitive doctors who may take patients away from the practice.

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*This article, by P.I.P. Richard Williams of Doctors Advisors Inc of Michigan, is based on an original article by Alan Thornberg.